



ALABAMA CHILD DEATH REVIEW SYSTEM REPORT

REPORT FOR COMPLETED 2010-2011 DATA

Learning from the Past to Protect the Future...

REPORT FOR 2010-2011 DATA

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT - 2010-2011 DATA

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A LETTER FROM THE STATE CHAIRMAN



September 18, 2014

The death of a child is a tragic, sentinel event for the child's family, their community, and our entire state, especially when such a death could have been prevented. There have been many efforts to prevent and reduce accidental, unexpected, and unexplained child deaths over the years. In order to develop effective prevention strategies, we must understand how, where, and why these deaths occur. That is the mission of the Alabama Child Death Review System (ACDRS).

The multidisciplinary methodology employed for child death review (CDR) began years ago with the systematic investigation of child abuse and neglect deaths, but it eventually grew in scope to include other causes of death. In 1997, ACDRS was created by law and funded primarily by the Children First Trust Fund. ACDRS reviews the circumstances and underlying factors of all infant and child deaths in Alabama in order to identify deaths which likely could have been prevented. Those preventable deaths are then reviewed in greater detail. The findings of these in-depth reviews, as well as recommendations drawn from them, are reported to state officials, state agencies, and to the general public. In addition to collecting and reporting data, ACDRS develops new literature and educational programs on various prevention topics including child passenger safety, teen driving, safe infant sleeping, youth suicide, and child abuse and neglect. The review findings are also used to make recommendations about policy changes at the state and local levels.

ACDRS consists of the State Office, Local CDR Teams throughout the state, and the State CDR Team. The State Office is responsible for program coordination and implementing strategies to make the public aware of ways to prevent future child injuries and deaths. The Local CDR Teams are responsible for the in-depth analysis of individual cases assigned to them by the State Office and for making recommendations about how to prevent future infant and child deaths. The State CDR Team is a 28-member multidisciplinary team which meets quarterly and serves as an advisory board, reviewing findings and recommendations rather than individual cases. Those involved with ACDRS at every level, as well as our invaluable strategic partners throughout the state, remain committed to the mission of reducing childhood injuries and fatalities in Alabama through education, awareness, and primary prevention efforts.

This report presents new data collected and analyzed related to infant and child deaths in Alabama since adopting new reporting procedures in 2008 as well as a brief summary of aggregate data collected prior to that change. It includes multi-year analysis, illustration of trends which inform our activities, and general injury and death prevention strategies. It also highlights some of the past successes, current challenges, and future plans of ACDRS. We hope that you will find this information useful and share it with other interested parties.



Sincerely,

Donald E. Williamson, M.D.
State Health Officer



Alabama Child Deaths

2010-2011

There were 1,589 children under the age of 18 who died in Alabama during the years 2010 and 2011. An examination of the deaths on a year-by-year basis reveals that in 2010 there were 804 deaths and in 2011 there were 785 child deaths in the state.

Each of these deaths is a tragedy, especially to family and friends. Each death also serves as a powerful warning that other children are at risk. To better understand how and why these children died, the Alabama Child Death Review System (ACDRS) has been empowered to: maintain statistics on child mortality; identify deaths that may be the result of abuse, neglect, or other preventable causes; and, from that information, develop and implement measures to aid in reducing the risk and incidence of future unexpected and unexplained child deaths in Alabama.

This report is a compilation of findings from Local Child Death Review Teams whose tasks are to: 1) identify factors that put a child at risk of injury or death; 2) share information among agencies that provide services to children and families or that investigate child deaths; 3) improve local investigations of unexpected/unexplained child deaths by participating agencies; 4) improve existing services and systems while identifying gaps in the community that require additional services; 5) identify trends relevant to unexpected/unexplained child deaths; and 6) educate the public about the causes of child deaths while also defining the public's role in helping to prevent such tragedies.

ACDRS was created by state law in 1997. What follows is a look at unexpected and unexplained child deaths in Alabama during 2010 and 2011.

This report seeks to honor the memory of all those children who have died in Alabama. We hope that this report, and the work of the various Child Death Review Teams and the Alabama Child Death Review System, leads to a better understanding of how we can all work together to make Alabama a safer and healthier place for children.



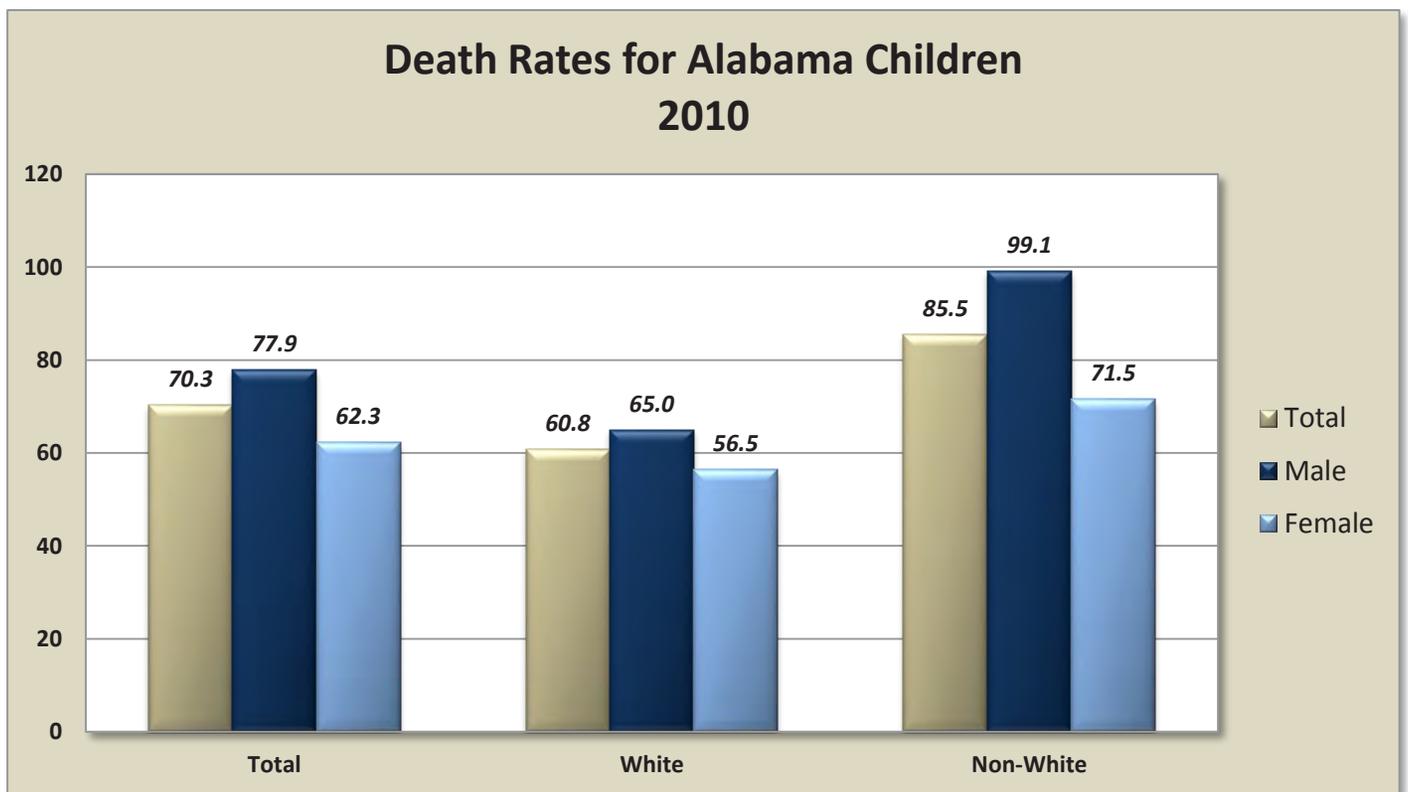
ALABAMA CHILD DEATHS 2010



KEY FINDINGS

- There were 804 infant and child deaths (those under the age of 18) during 2010.
- The 2010 findings represent approximately 70.3 deaths per 100,000 children.*
- Of the deaths, 56.7 percent were male children.
- Of the deaths, 46.6 percent were non-white children.

- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2010. The graph allows for comparison of death rates among specific population groups.*

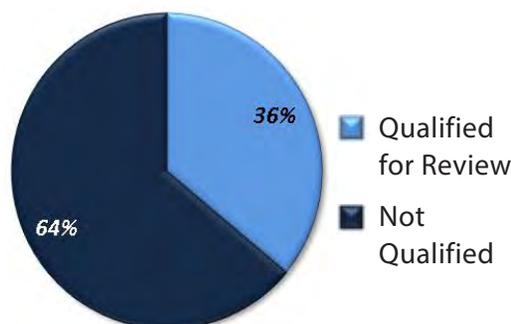


* Please note that race and/or gender information was unavailable for eight deaths in 2010 which results in an underestimation in the death rates for 2010.

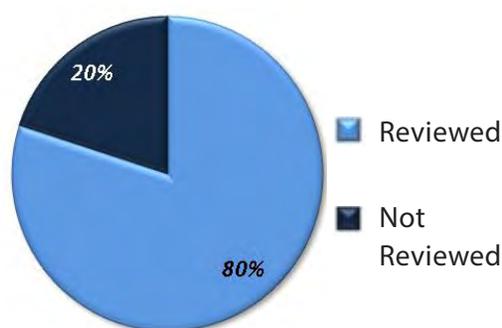


KEY FINDINGS

- As the chart below indicates, of the 804 child deaths in Alabama in 2010, there were 288 deaths that year that qualified for review under the Alabama Child Death Review System



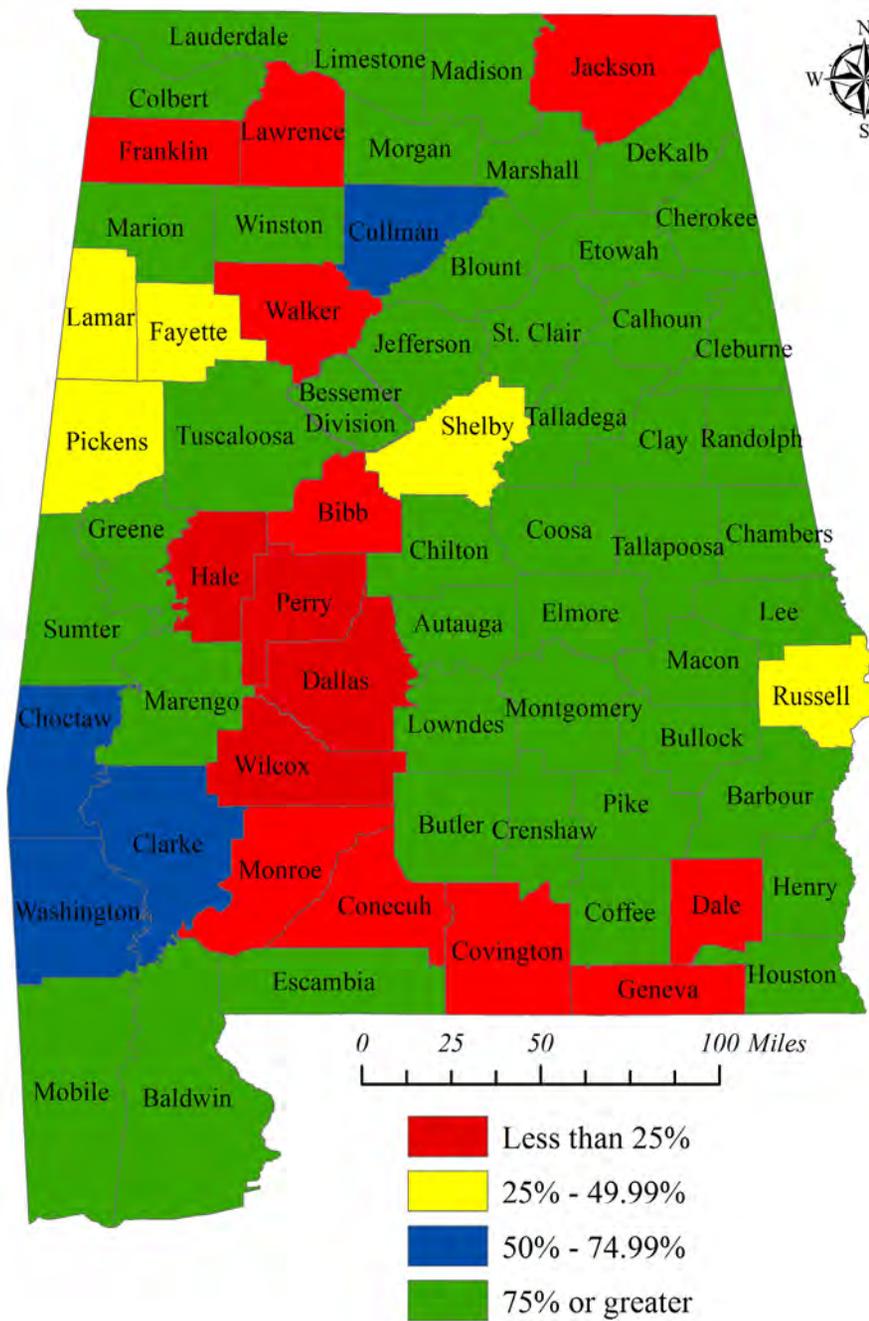
- Of the deaths that qualified for review (288), the Local Child Death Review Teams reviewed and returned 232 reports (see chart below). There was no significant change in percentage of reviews complete from 2009.



- There were no significant gender differences between those who were and those who were not reviewed. Significantly more non-white cases were reviewed in 2010.

<i>AGE GROUP</i>	<i>ALL</i>	<i>QUALIFIED</i>	<i>REVIEWED</i>	<i>QUALIFIED BUT NOT REVIEWED</i>
< 28 days	315	15	11	4
28 days – < 1 year	186	90	80	10
1 year – < 5 years	78	39	28	11
5 years – < 10 years	59	33	25	8
10 years – < 16 years	86	47	34	13
16 years – < 18 years	80	66	54	12

- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2010. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



Teams

- 1 - Choctaw, Clarke, Washington
- 2 - Butler, Crenshaw, Lowndes
- 3 - Barbour, Bullock
- 4 - Bibb, Dallas, Hale, Perry, Wilcox
- 5 - Chambers, Macon, Tallapoosa, Randolph
- 6 - Tuscaloosa
- 7 - Calhoun, Cleburne
- 8 - Morgan
- 9 - Cherokee, DeKalb
- 10A - Jefferson
- 10B - Bessemer Division
- 11 - Lauderdale
- 12 - Coffee, Pike
- 13 - Mobile
- 14 - Walker
- 15 - Montgomery
- 16 - Etowah
- 17 - Greene, Marengo, Sumter
- 18 - Shelby
- 19 - Autauga, Chilton, Elmore
- 20 - Henry, Houston
- 21 - Escambia
- 22 - Covington
- 23 - Madison
- 24 - Fayette, Lamar, Pickens
- 25 - Marion, Winston
- 26 - Russell
- 27 - Marshall
- 28 - Baldwin
- 29 - Talladega
- 30 - St. Clair
- 31 - Colbert
- 32 - Cullman
- 33 - Dale, Geneva
- 34 - Franklin
- 35 - Conecuh, Monroe
- 36 - Lawrence
- 37 - Lee
- 38 - Jackson
- 39 - Limestone
- 40 - Clay, Coosa
- 41 - Blount

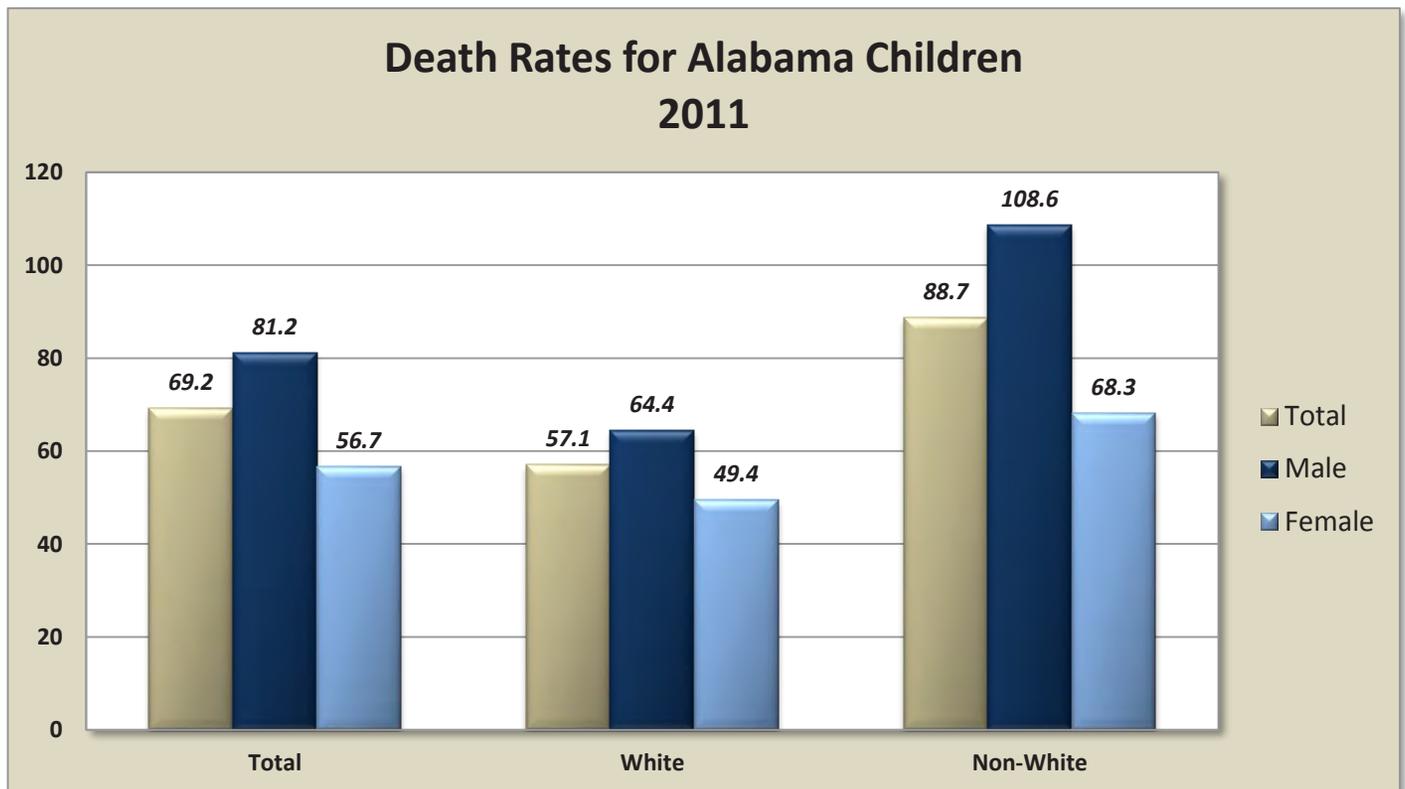
ALABAMA CHILD DEATHS 2011



KEY FINDINGS

- There were 785 infant and child deaths (those under the age of 18) during 2011.
- The 2011 findings represent approximately 69.2 deaths per 100,000 children.
- Of the deaths, 60 percent were male children.
- Of the deaths, 49.2 percent were non-white children.

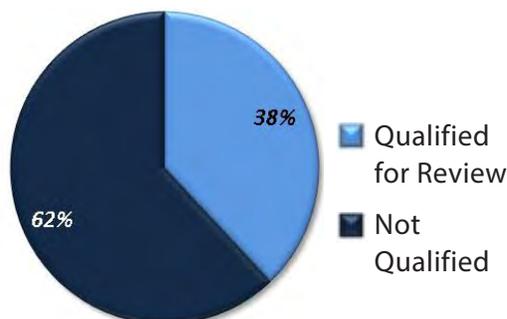
Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2011. The graph allows for comparison of death rates among specific population groups.



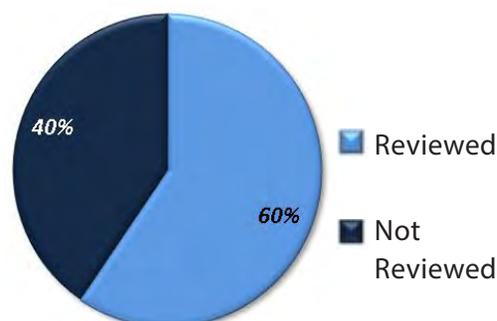


KEY FINDINGS

- As the chart below indicates, of the 784 child deaths in Alabama in 2011, there were 299 deaths that year that qualified for review under the Alabama Child Death Review System.



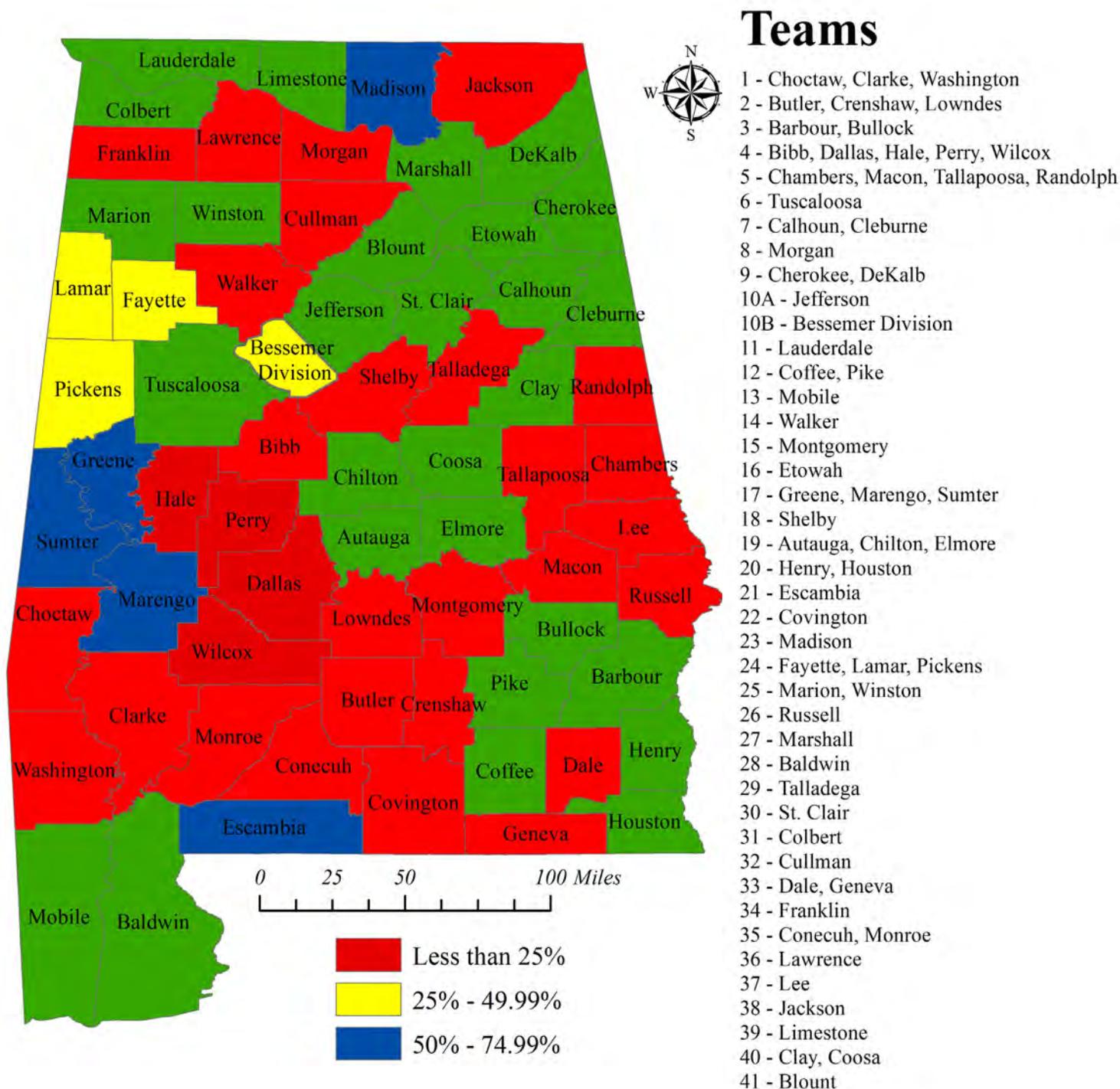
- Of the deaths that qualified for review (299), the Local Child Death Review Teams reviewed and returned 180 reports (see chart below). There was a significant decrease in the percentage of reviewed deaths from 2010.



- In 2011, there was no significant difference in gender in the proportion of cases reviewed compared to those cases not reviewed. Significantly fewer white cases were reviewed when compared to non-white reviewed cases.

<i>AGE GROUP</i>	<i>ALL</i>	<i>QUALIFIED</i>	<i>REVIEWED</i>	<i>QUALIFIED BUT NOT REVIEWED</i>
< 28 days	297	9	6	3
28 days – < 1 year	175	84	55	29
1 year – < 5 years	95	65	43	22
5 years – < 10 years	58	36	24	12
10 years – < 16 years	87	47	23	24
16 years – < 18 years	72	58	27	31

- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2011. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



2010-2011 CATEGORIES OF DEATH





KEY FINDINGS

- A total of 60 motor vehicle involvement cases were reviewed in 2010.
- Fourteen of these deaths (23.3 percent) involved young drivers (those 16 years to 17 years of age).
- Two of these deaths (3.3 percent) involved underage drivers (those under the age of 16).
- Eight of the deaths (13.3 percent) were listed as being due to an inexperienced driver.
- In 12 deaths (20 percent), lap and shoulder belts were present but not used. One death (1.7 percent) was the result of restraints not being used correctly.
- Additionally, 17 of these deaths (28.3 percent) were caused by speeding, nine of these deaths (15 percent) were caused by reckless driving, and four deaths (6.7 percent) were caused by driver distraction.





KEY FINDINGS

- A total of 35 motor vehicle involvement cases were reviewed in 2011.
- Four of these deaths (11.4 percent) involved young drivers (those 16 years to 17 years of age).
- One of these deaths (2.9 percent) involved underage drivers (those under the age of 16).
- Five of the deaths (14.3 percent) were caused by driver inexperience.
- For five of these deaths (14.3 percent), lap and shoulder belts were present but not used.
- Additionally, two of these deaths (5.7 percent) were caused by speeding, four of the deaths due to motor vehicle involvement (11.4 percent) were caused by reckless driving, and three deaths (8.6 percent) were caused by cell phone use while driving.

RECOMMENDATIONS

1. Support further enhancements and improvements to the Alabama Graduated Driver's License Law, Alabama's Child Passenger Restraint Laws, and the enforcement thereof.
2. Promote the Alabama Child Death Review System Teen Driver Safety Campaign (brochures, website, etc.).
3. Encourage auto dealerships to provide point-of-sale information resources about proper installation and usage of child safety seats and booster seats when selling new or used vehicles.
4. Promote All-Terrain Vehicle (ATV) safety and encourage the establishment of safety standards, including a minimum age for operating full-size ATVs.
5. Reinstate and restore full funding for the former Alabama Child Passenger Safety Program.
6. Promote public awareness of the dangers of leaving a child unattended in a vehicle.



KEY FINDINGS

- Fifteen suspected cases of Sudden Unexplained Infant Death (SUID) were reviewed in 2010.
- The initial sleeping position of 13.3 percent of the babies whose deaths were reviewed is not known; however 13.3 percent were placed on their stomachs, which is a known risk factor for SUID.
- Of those cases reviewed, seven infants (46.7 percent) were sleeping in adult beds and 46.7 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge about the deaths in cases where the position of the infant was unknown.





KEY FINDINGS

- Thirteen suspected cases of Sudden Unexplained Infant Death (SUID) were reviewed in 2011.
- Five infants (38.5 percent) were placed on their stomachs to sleep, which is a known risk factor for SUID.
- Of those cases reviewed, six infants (46.15 percent) were sleeping in adult beds and four (30.8 percent) were not sleeping alone. In addition, two infants (15.4 percent) were sleeping on a couch. These numbers may not fully represent the situation given our lack of knowledge about the deaths in cases where the position of the infant was unknown.

RECOMMENDATIONS

1. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
2. Increase public awareness of “Safe to Sleep” and “Babies Sleep Safest on Their Backs” programs.
3. Teach and promote the use of Alabama’s Sudden Unexplained Infant Death Investigation (SUIDI) protocols.
4. Provide increased public education and encourage strict adherence to the American Academy of Pediatrics guidelines for preventing SUID and reducing risks associated with infant sleeping environments.
5. Ensure that all child deaths in Alabama are reported to the appropriate authorities.
6. Help to ensure that forensic lab capacity is sufficient to meet the needs of the state.





KEY FINDINGS

- Thirteen cases of fire-related deaths were reviewed in 2010.
- In five of these cases (38.5 percent), fire was the result of a cooking stove in the child's place of residence.
- Smoke detectors were absent in one case (7.7 percent) of fire-related death.
- Two cases (15.3 percent) of fire-related death occurred in an apartment home. Three cases (23.1 percent) occurred in a single home.
- In 11 of the cases (84.6 percent), the child died of smoke inhalation.





KEY FINDINGS

- Fourteen cases of fire-related deaths were reviewed in 2011.
- In three of these cases (21.4 percent), fire was the result of a cigarette lighter and in three cases (21.4 percent) a cooking stove caused the fire. In 14.3 percent of cases, a space heater was the cause of the fire.
- Two cases (14.3 percent) occurred in a mobile home. Seven cases (50 percent) occurred in a single home, while four cases (28.6 percent) occurred in an apartment.
- In one case the child died of burns, while 12 (85.7 percent) of the fire-related deaths resulted from smoke inhalation.

RECOMMENDATIONS

1. Encourage enforcement of laws governing smoke detector installation, testing, and inspection in all homes, including new and used manufactured homes.
2. Support local fire departments in developing, expanding, and implementing fire education activities, particularly for elementary schools and child-care facilities.
3. Encourage community education efforts about the need for installation and periodic testing of smoke detectors in homes, businesses, and places of worship.
4. Encourage families to prepare, discuss, and practice a “Home Fire/Emergency Plan” for their households.





KEY FINDINGS

- Twelve drowning cases were reviewed in 2010.
- Eight of these deaths (66.7 percent) occurred in a swimming pool, hot tub or spa.
- Two of these deaths (16.7 percent) occurred in open water. One death (8.3 percent) occurred in a in a bathtub.
- Of the 18 drowning deaths, in four cases (33.3 percent) a flotation device was not being used.
- In eight of the cases (66.7 percent), it was reported that the child was unable to swim.





KEY FINDINGS

- Twelve drowning cases were reviewed in 2011.
- Seven of these deaths (58.3 percent) occurred in a swimming pool, hot tub or spa.
- Three of these deaths (25 percent) occurred in open water. Two cases (16.7 percent) occurred in a bathtub.
- A personal flotation device was not being used in eight of the twelve cases (66.7 percent).
- In eight of the cases (66.7 percent), it was reported that the child was unable to swim.

RECOMMENDATIONS

1. Support public education and awareness campaigns about water safety. Place special emphasis on the need for constant adult supervision and focus on pools, bathtubs, and open bodies of water.
2. Encourage enforcement of ordinances regarding pool fencing and signage.
3. Persuade communities to seek ways to make swimming lessons and water safety classes more readily available to children and parents.
4. Encourage the use of flotation devices and the “buddy system” when swimming in or boating/fishing on open bodies of water.





KEY FINDINGS

- Twenty-six cases of suffocation-related deaths were reviewed in 2010.
- Seven cases of suffocation and eight cases of strangulation were reviewed in 2010.
- In six cases (24 percent), the suffocation was reported to be sleep-related (e.g. bedding, overlay, wedged). (Note: This is not a duplication of cases identified in the Sudden Unexplained Infant Death section.)
- Seven of these victims (26.9 percent) were reported to be sleeping in an adult bed when the death occurred. Four deaths (15.4 percent) occurred while a child was sleeping on a couch.
- A belt was used in four cases of strangulation (16 percent), while a rope or string was used in four additional cases (16 percent).





KEY FINDINGS

- Fourteen cases of suffocation-related deaths were reviewed in 2011.
- Five cases of suffocation and five cases of strangulation were reviewed in 2011.
- In five cases (35.7 percent), the suffocation was reported to be sleep-related (e.g. bedding, overlay, wedged). (Note: This is not a duplication of cases identified in the Sudden Unexplained Infant Death section.)
- Two of these victims (14.3 percent) were reported to be sleeping in an adult bed when the death occurred. Two deaths (14.3 percent) occurred while a child was sleeping on a couch.
- A belt was used in one case of strangulation (7.1 percent), while a rope or string was used in three additional cases (21.4 percent).

RECOMMENDATIONS

1. Promote and encourage statewide education and awareness campaigns about safe sleeping practices and the dangers of bed sharing.
2. Promote and encourage parenting classes for new and, especially, young parents.
3. Provide increased public education and encourage strict adherence to the 2010 American Academy of Pediatrics guidelines for reducing risks associated with infant sleep environment.





KEY FINDINGS

- Thirty-two cases of firearm/weapon-related deaths were reviewed in 2010.
- Twenty-three of these deaths (71.9 percent) were the result of firearm use, with 14 deaths (43.8 percent) involving handguns and three deaths (9.4 percent) involving a rifle or shotgun.
- Two deaths (6.3 percent) involved sharp instruments.
- In four cases (12.5 percent), the use of the weapon at the time was for the commission of crime. In three cases (9.4 percent), the weapon was used during an argument.
- Three of the deaths (9.4 percent) reviewed in this category were reported to be the result of playing with firearms. In two cases (6.3 percent), the weapon was used in gang-related activity.





KEY FINDINGS

- Twenty-one cases of firearm/weapon-related deaths were reviewed in 2011.
- Four cases (19.1 percent) were the result of a person's body part used as a weapon.
- Thirteen of these deaths (61.9 percent) were the result of firearm use, with seven deaths (33.3 percent) caused by handgun use and four deaths (19 percent) involved a shotgun or rifle.
- In six cases (28.6 percent), the use of the weapon at the time was for the commission of crime. Two of the cases (9.5 percent) reviewed in this category were reported to be the result of random violence. Two cases (9.5 percent) were the result of a drive-by shooting.
- Five of the 21 children (23.8 percent) were killed by a weapon being handled by a family member or parent's partner.

RECOMMENDATIONS

1. Encourage safe and secure storage of firearms.
2. Encourage gun safety education for children and parents.
3. Support crisis team and victim advocacy for children who witness violence.
4. Support after-school and evening education and recreation programs for high-risk youth.
5. Encourage community-based violence prevention programs.

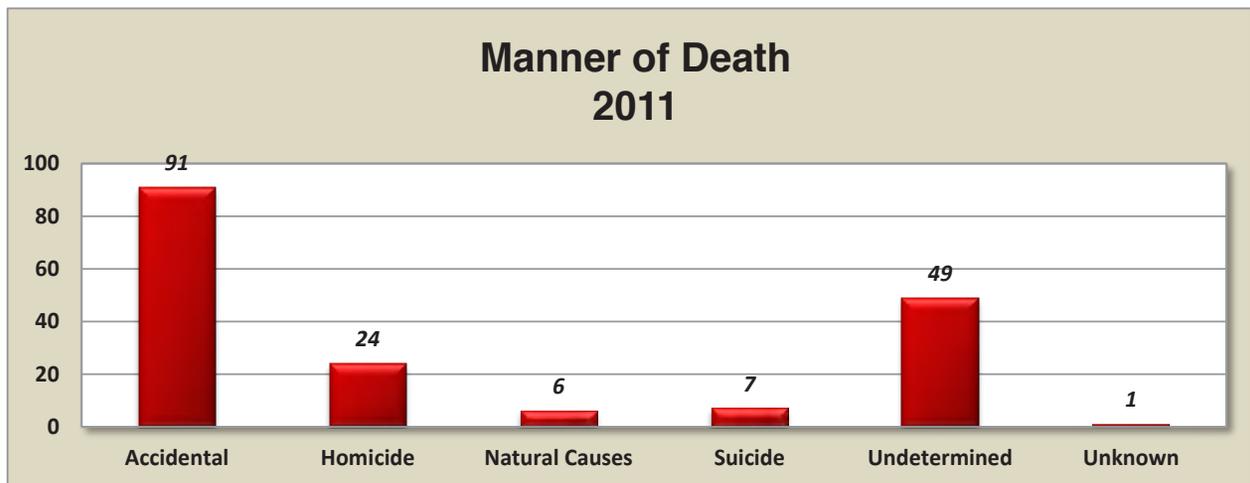
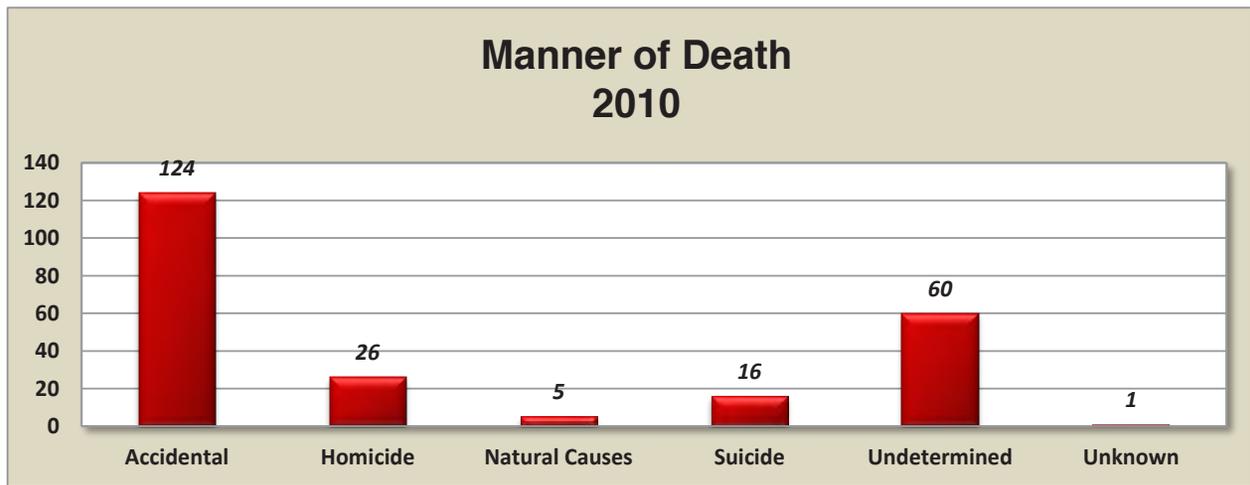


OTHER FINDINGS

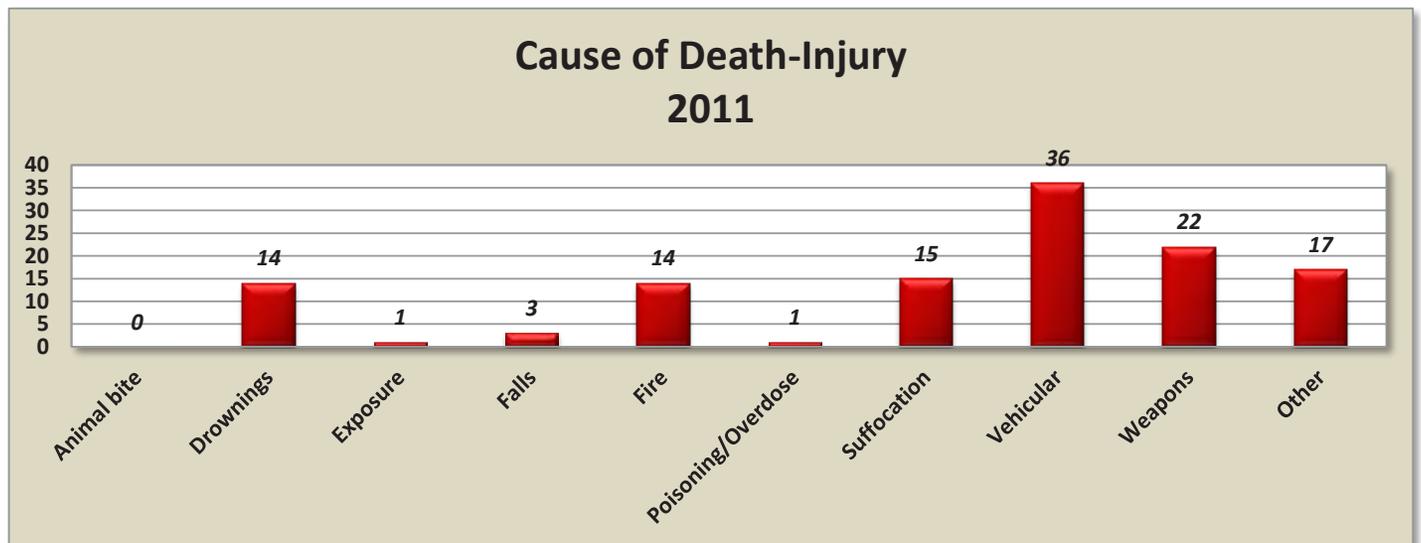
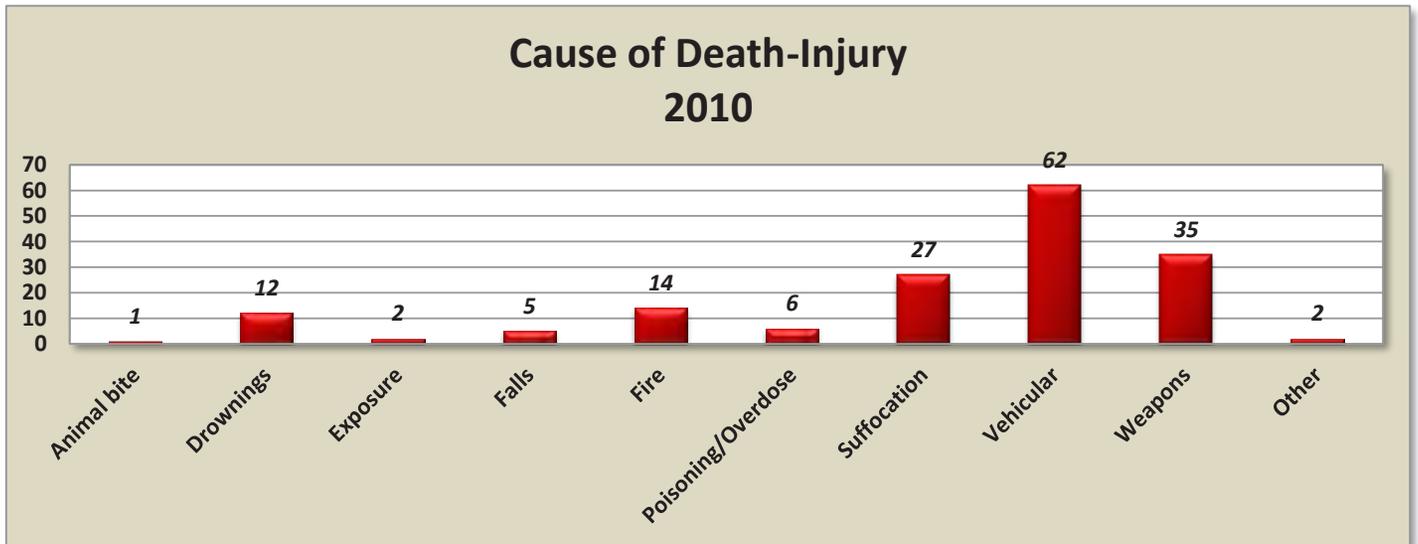


REVIEWED CASES ONLY

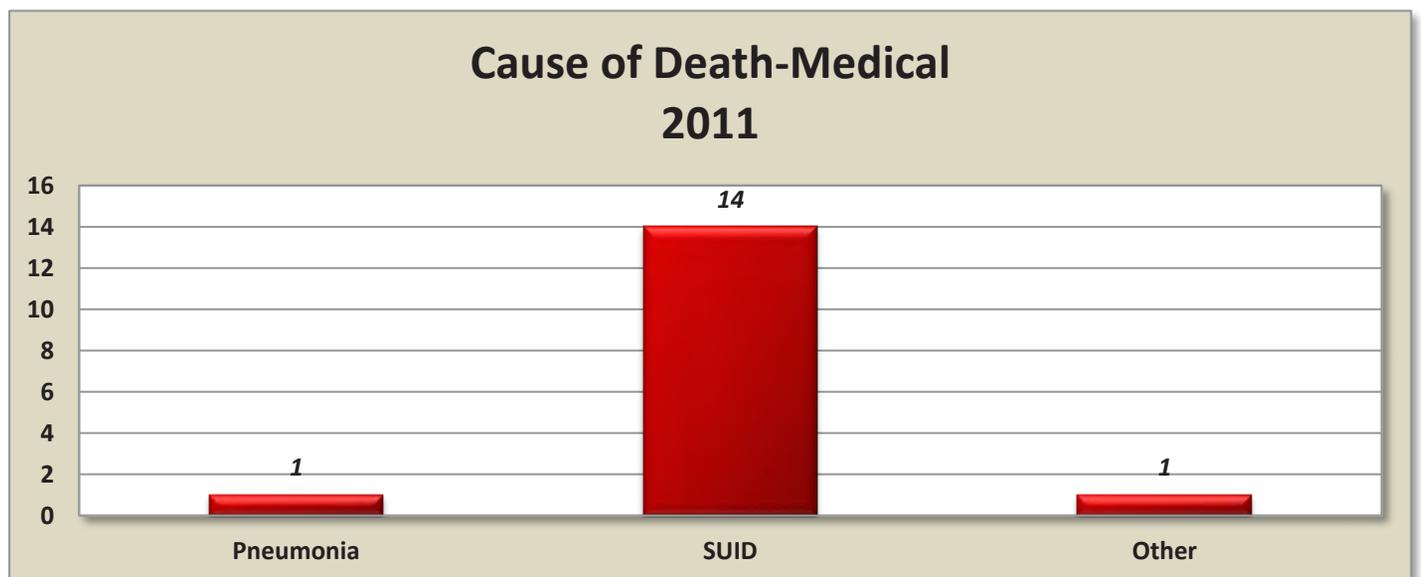
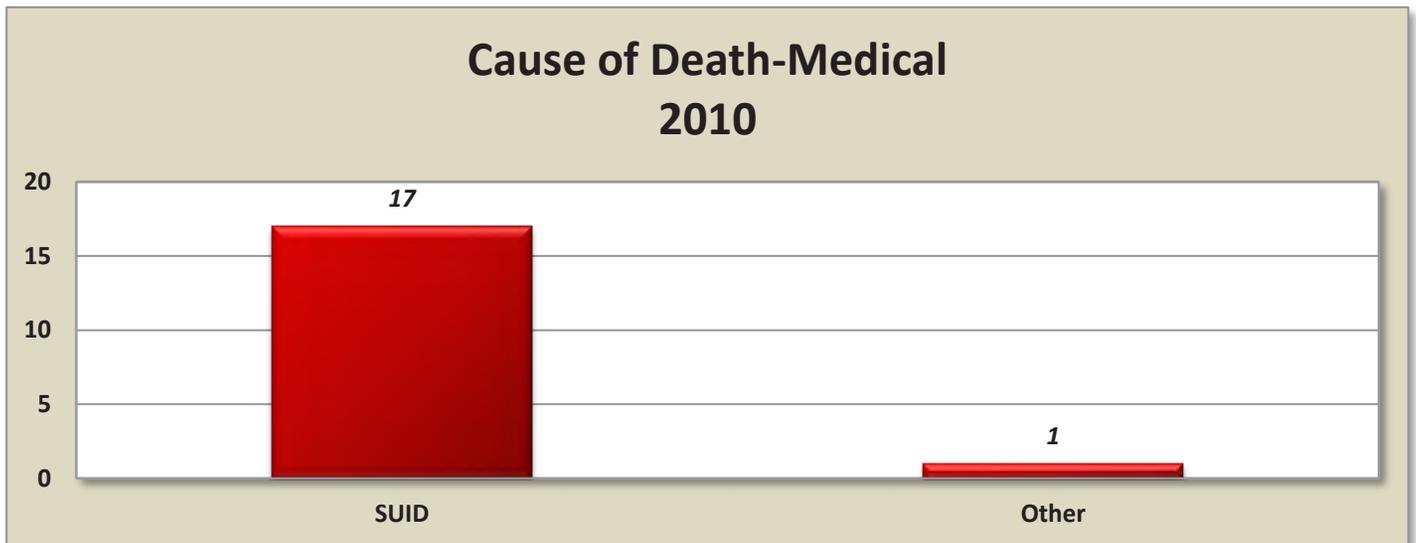
- Accident was the most frequently reviewed manner of death in 2010 (53.4 percent) and 2011 (51 percent).



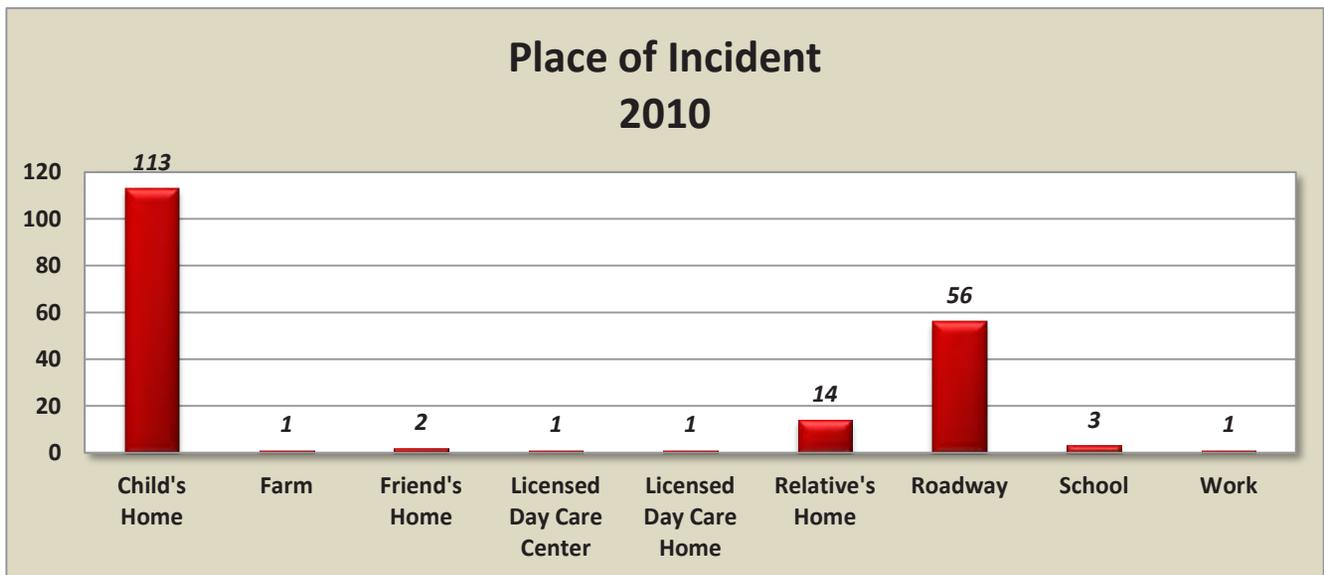
- Motor vehicle involvement was the most frequently reviewed cause of child death from an injury in 2010 (37 percent) and 2011 (29 percent).



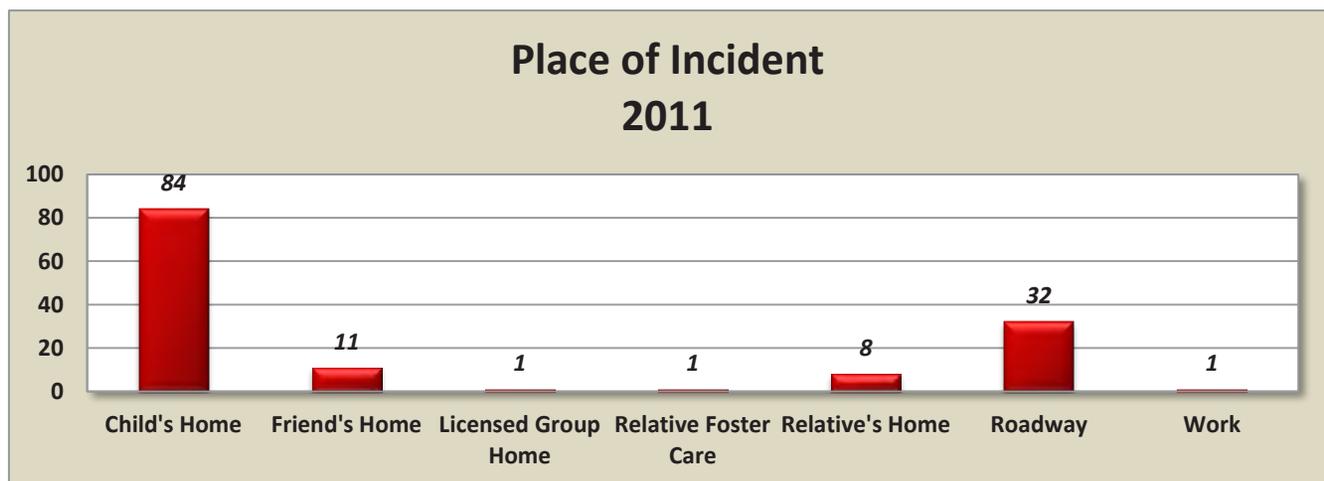
- SUID was the most frequently reviewed case of child death from a medical cause in 2010 (94 percent) and 2011 (88 percent).



- In 2010, the child's home was the single most frequent place of incident (59 percent) followed by the roadway (29 percent).



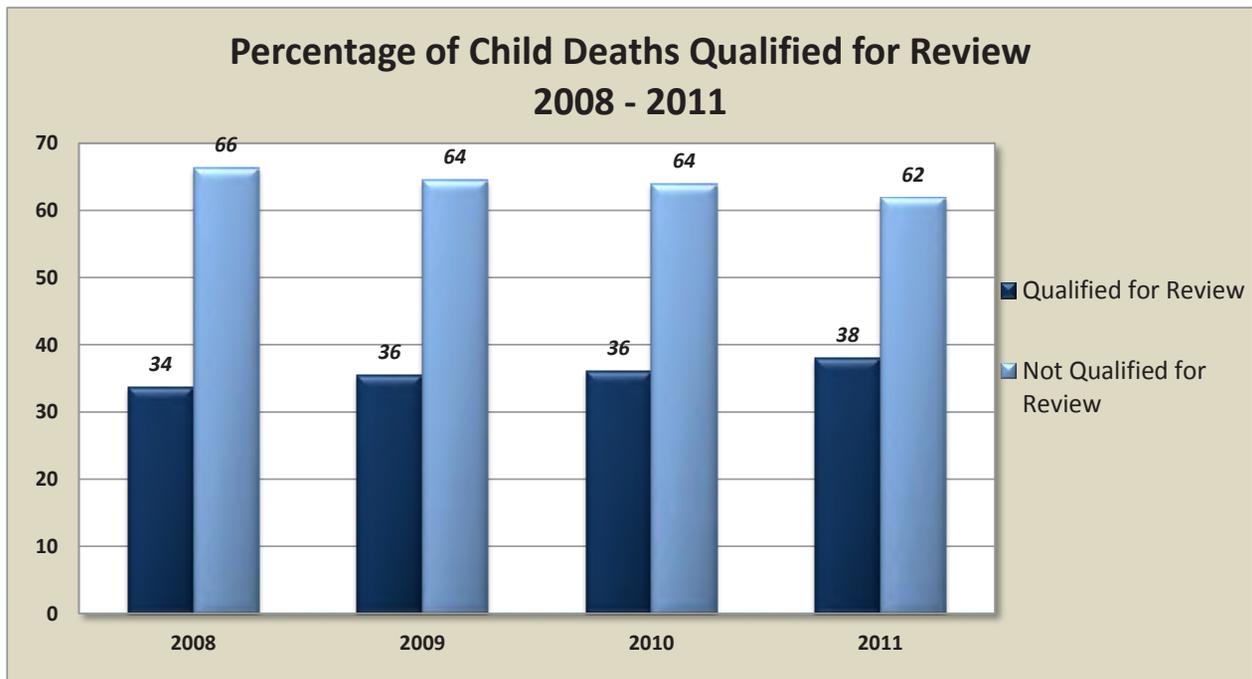
- In 2008, the child's home was the single most frequent place of incident (50 percent) followed by the roadway (25 percent).



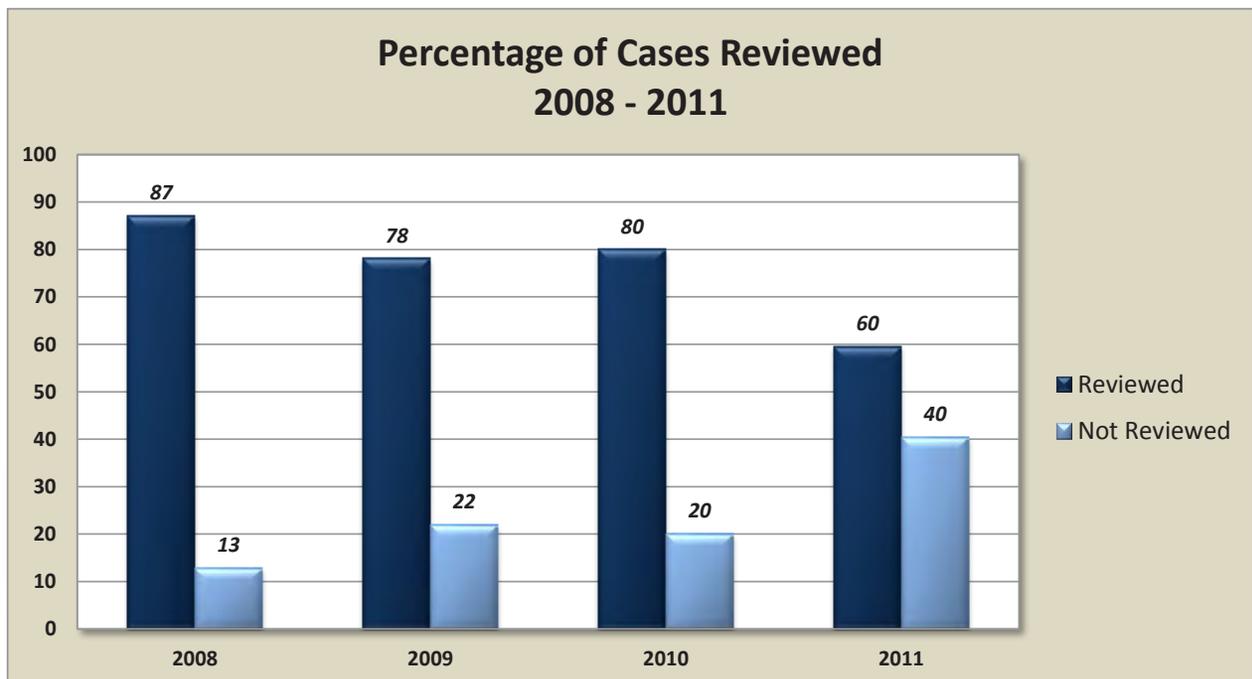
Alabama Child Deaths: 2008-2011



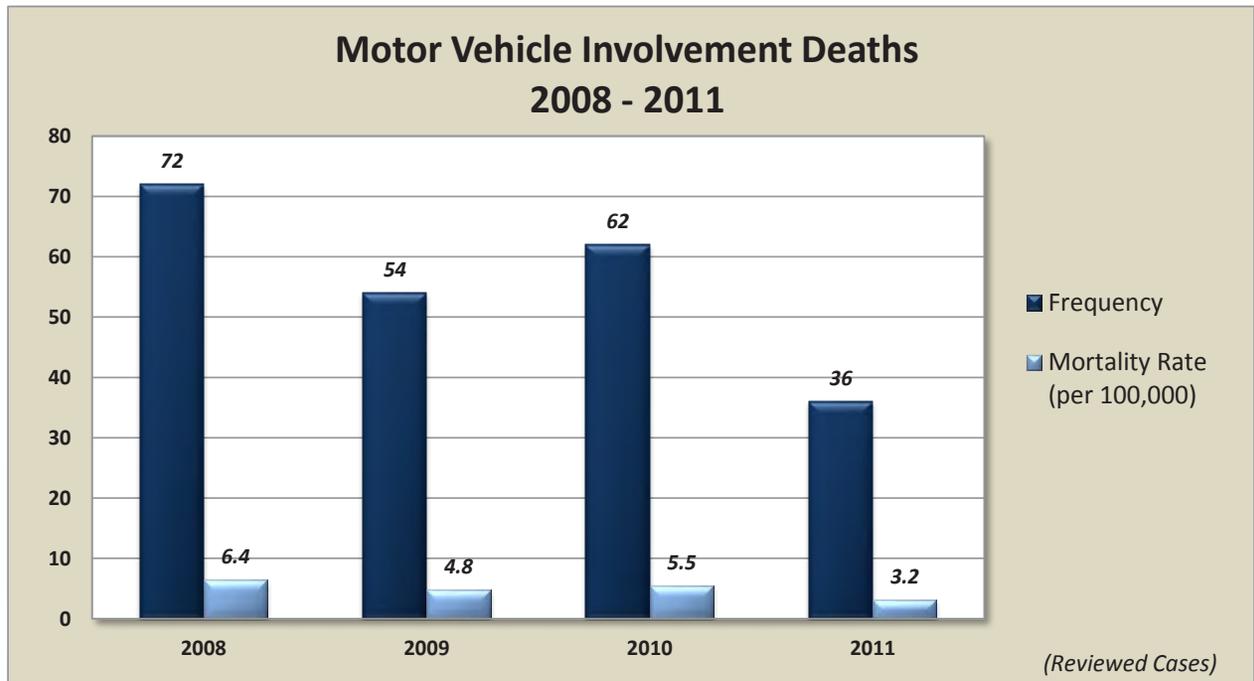
- Of the 3,309 child deaths that occurred during the years 2008 through 2011, those that qualified for review under the Alabama Child Death Review System totaled 1,183 (35.7 percent).



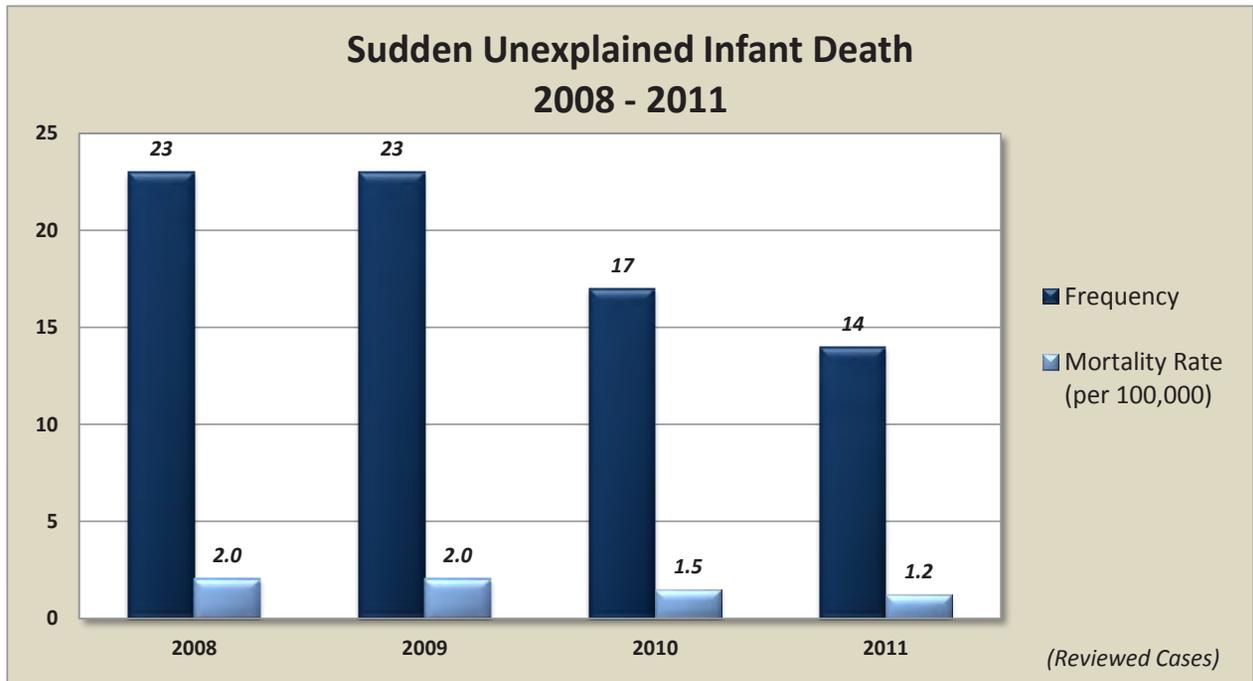
- Of the total number of deaths that qualified for review during the years 2008 through 2011, the Local Child Death Review Teams reviewed and returned 902 cases (76.2 percent). The percentage of cases that qualified for review and were reviewed has decreased over the four year period.



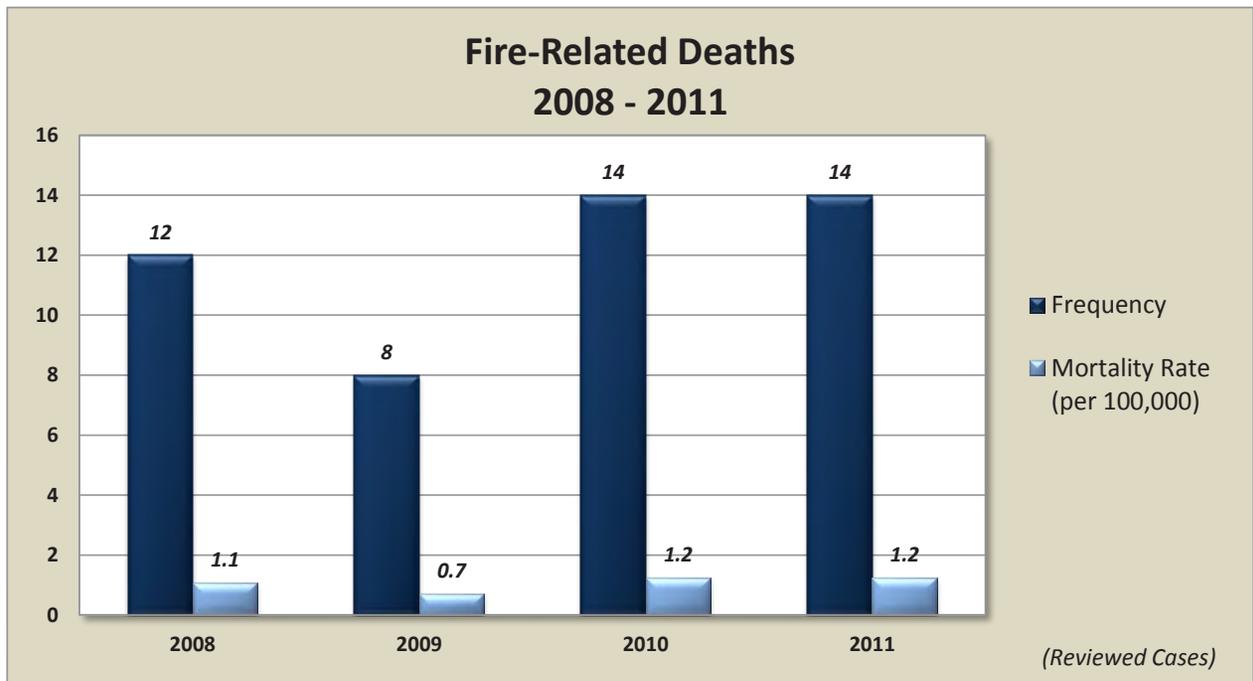
- Of the cases reviewed, motor vehicle mortality rates have varied of the four-year period.



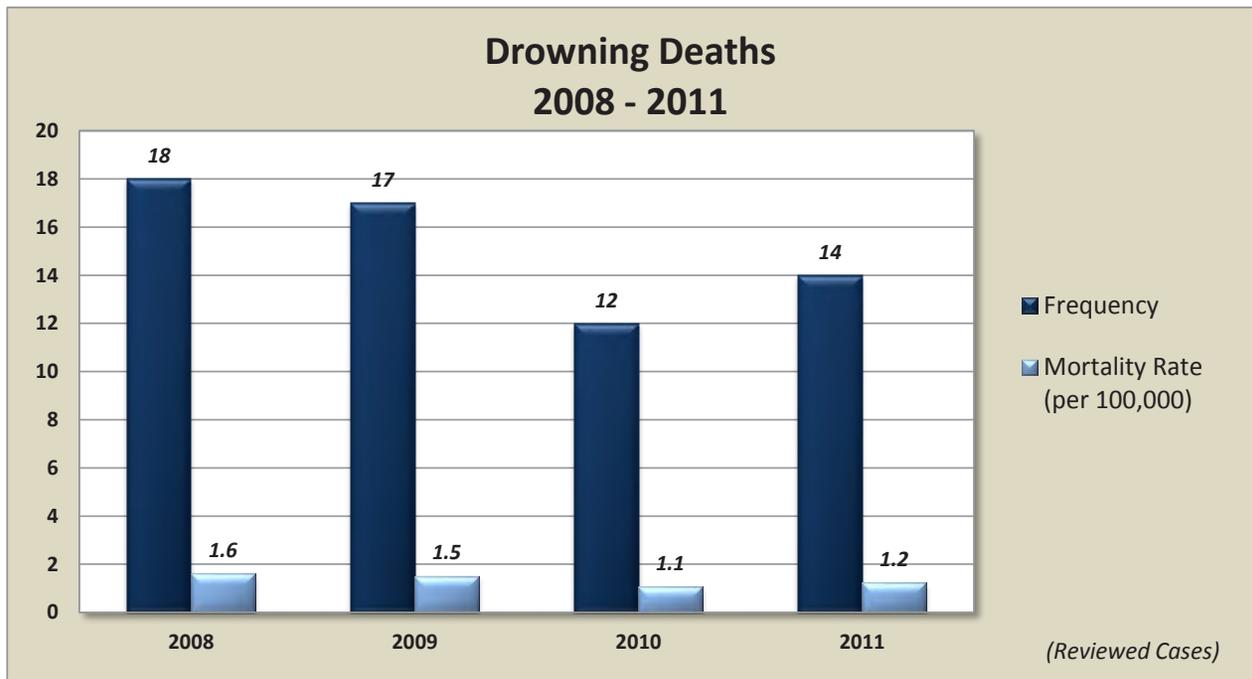
- The Sudden Unexplained Infant Death mortality rates (reviewed cases) have decreased over the four-year span.



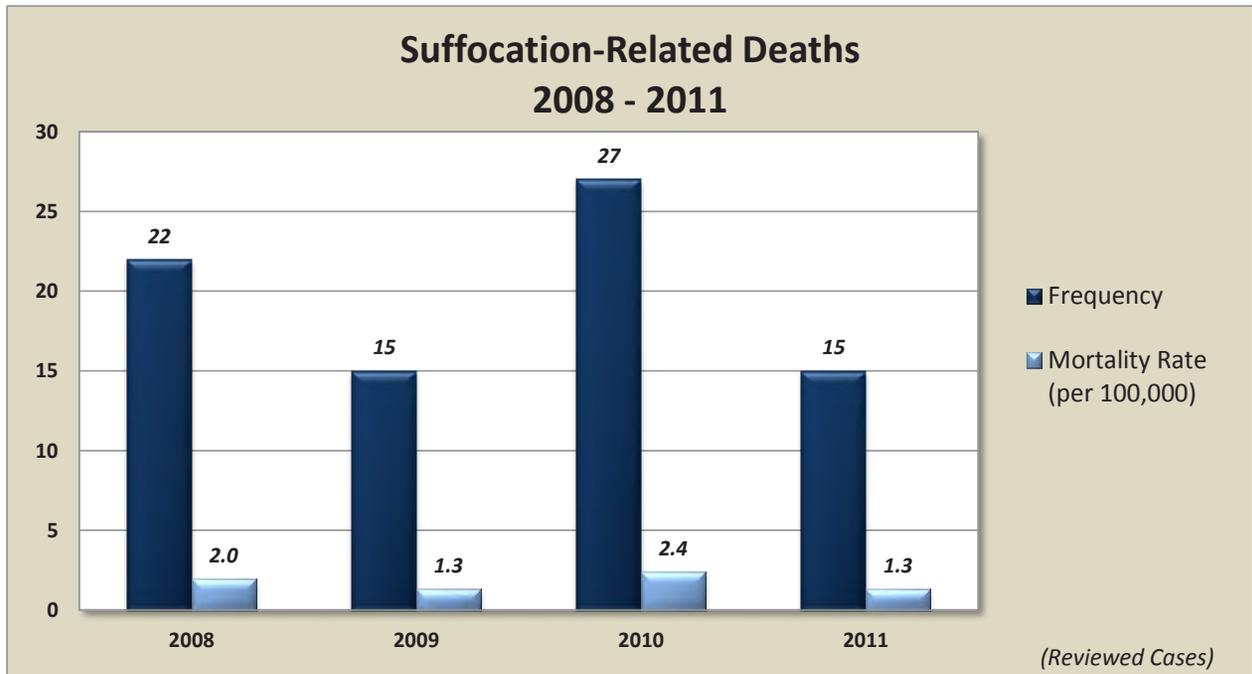
- Reviewed cases of fire-related death have increased over the four-year period.



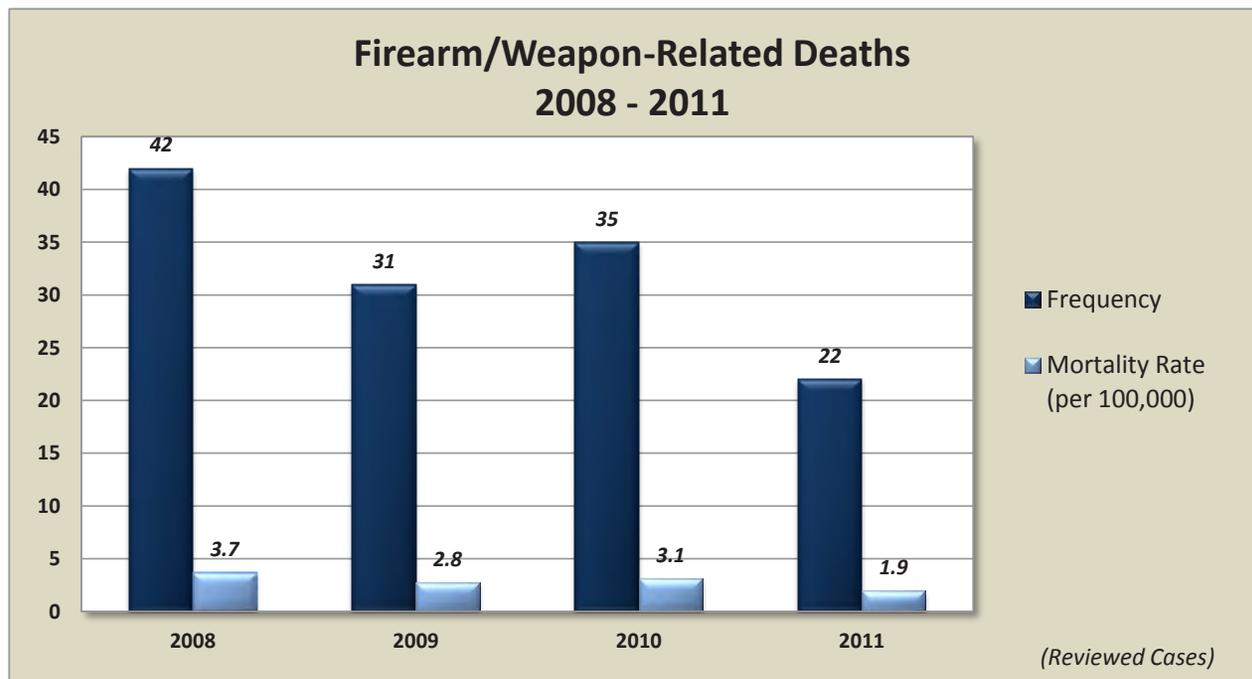
- Deaths reviewed due to drowning have varied over the four-year period.



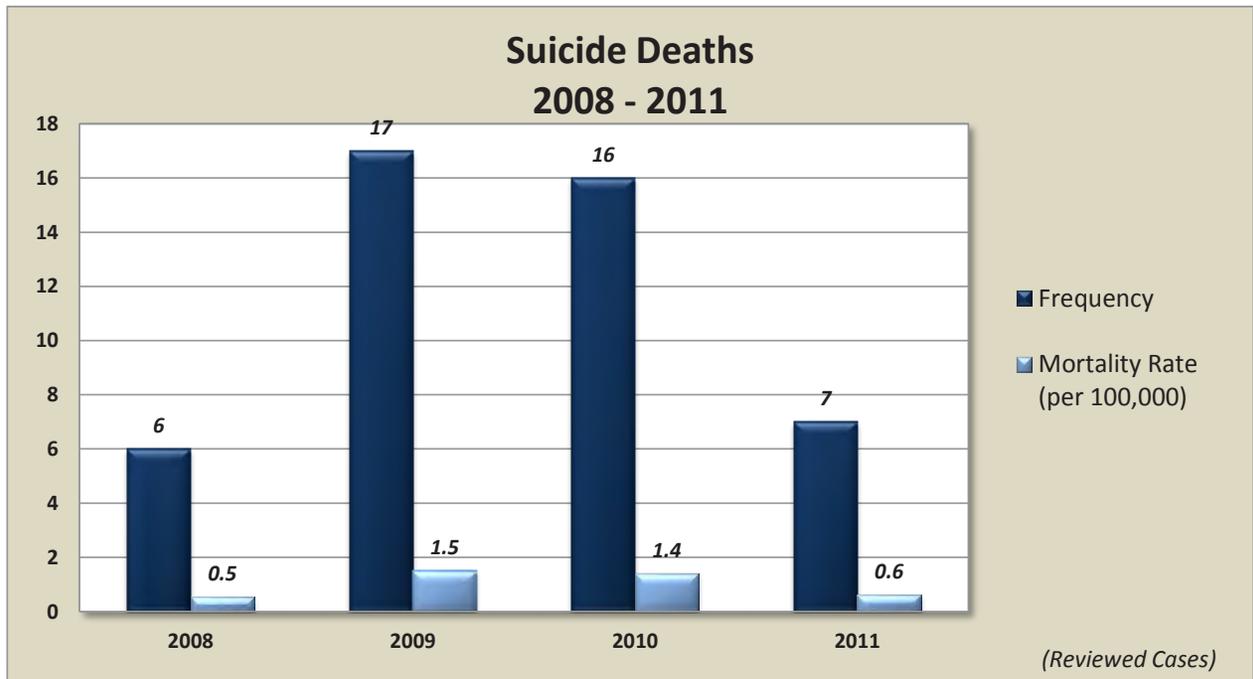
- Suffocation-related deaths have also varied over the four years examined.



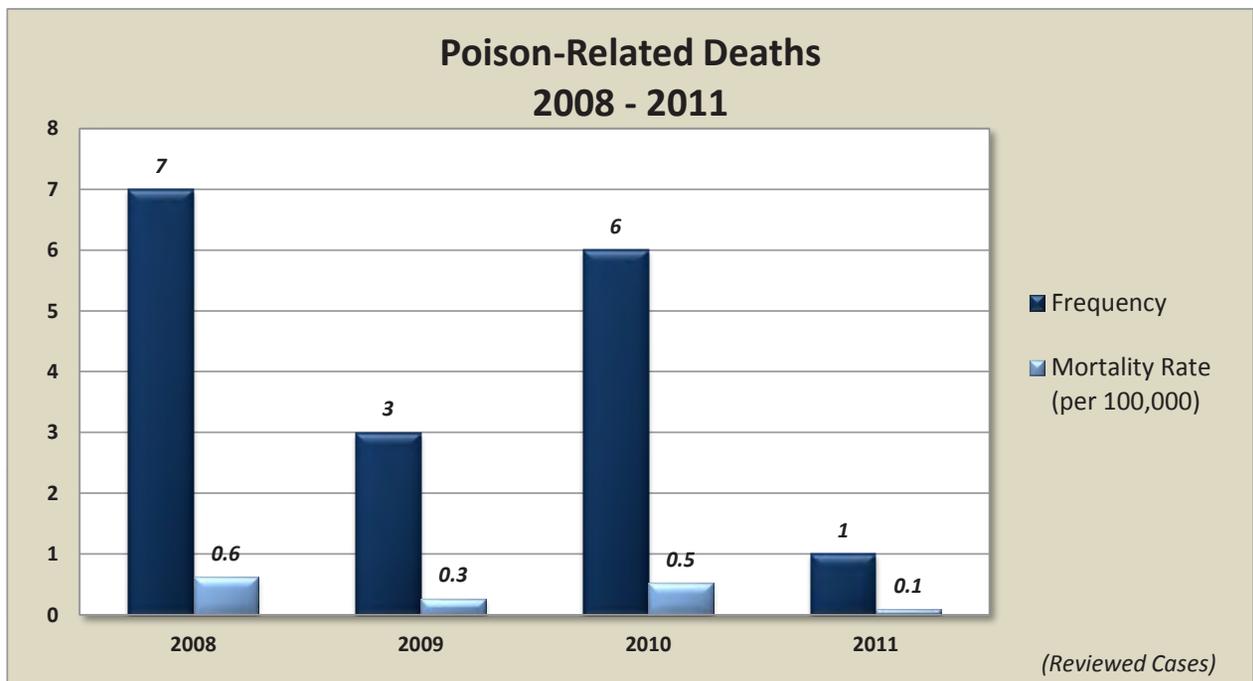
- Reviewed cases of death due to firearms or weapons varied between 2008 and 2011.



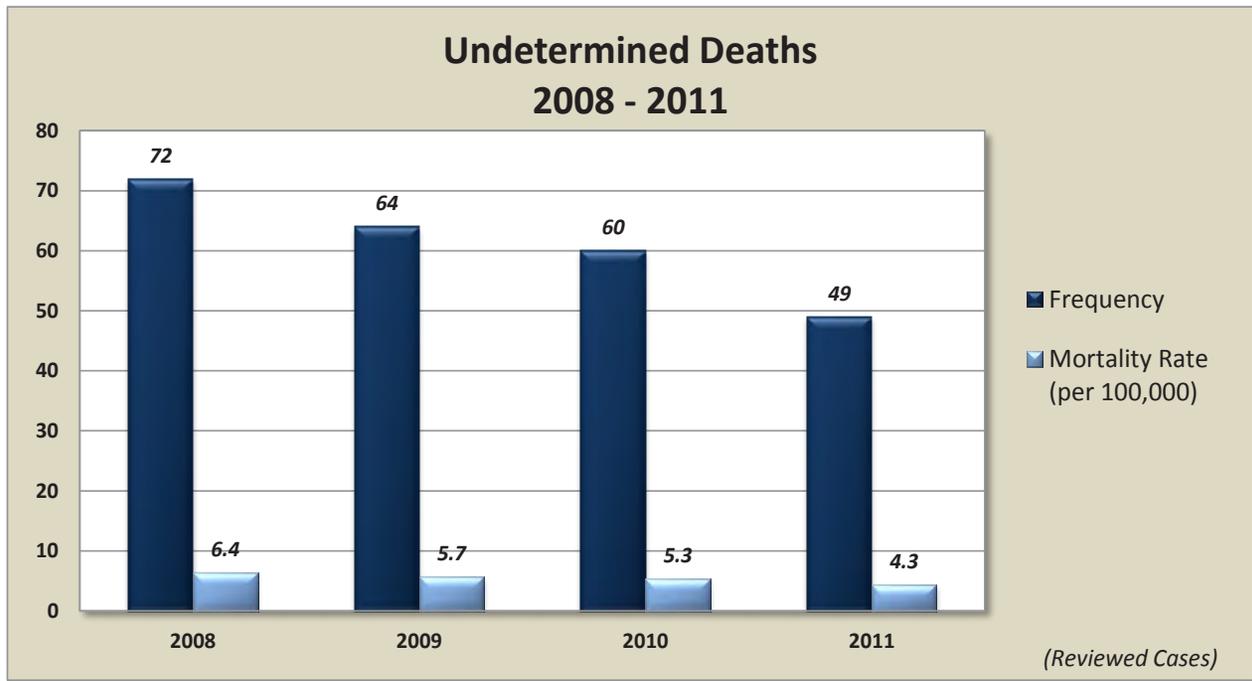
- Reviewed cases of suicide have fluctuated over the four-year period.



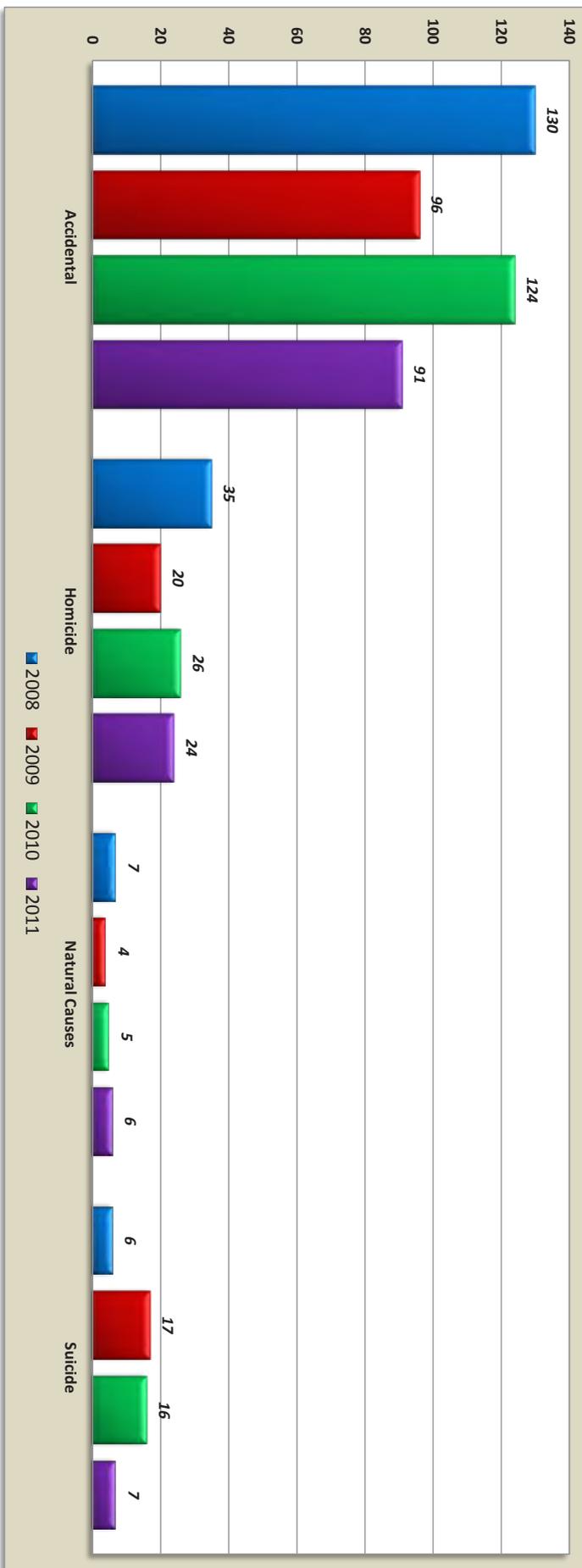
- Reviewed cases of poison-related deaths also varied.



- The number of undetermined deaths from 2008 through 2011 has decreased.

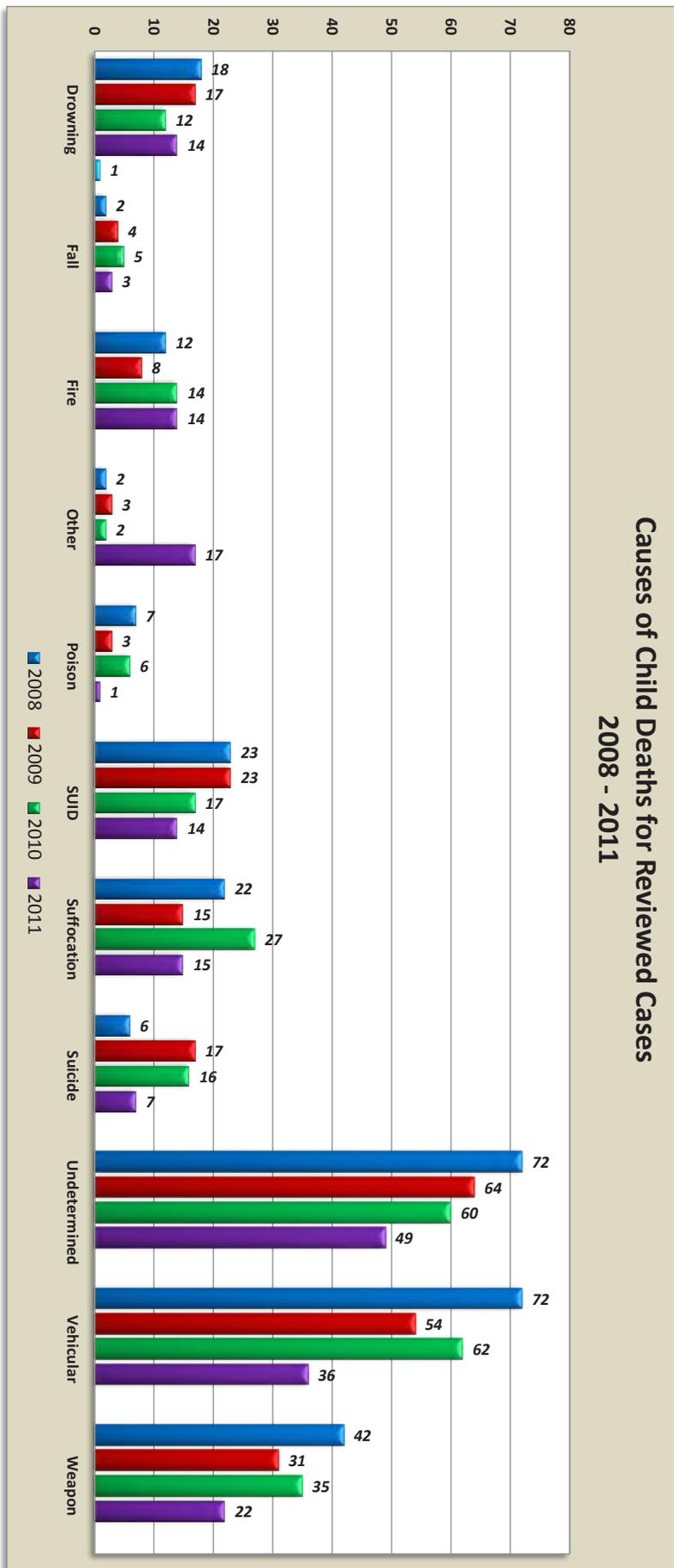


Manner of Child Deaths for Reviewed Cases 2008 - 2011



- The chart displays some fluctuation by year, although undetermined deaths show a slight increase while natural causes have decreased. This is possibly explained by reclassification of some child-related deaths.

Causes of Child Deaths for Reviewed Cases 2008 - 2011



- Vehicular deaths are consistently the leading cause of preventable child death in Alabama. The second leading category is infant sleep-related deaths, which includes all of the SIDS deaths above, most of the undetermined deaths, and many of the suffocation deaths.



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The Alabama Child Death Review System (ACDRS) continues to review unexpected infant and child deaths in our state. The mission is to understand how and why children die in Alabama in order to prevent other child deaths. Each year, approximately one-third of all child deaths in Alabama are considered preventable.

Since 2000, local review teams have reviewed more than 4,000 child deaths and recommendations implemented to support prevention efforts. More recently, the ACDRS transitioned to a web-based national data collection system to enhance the reporting process and data collected. Through biennial training conferences, the ACDRS has offered program-specific training, state and national trends, and other related initiatives to state and local review team members.

VOICES for Alabama’s Children recently released the 25th annual “KIDS COUNT Data Book” on child well being and listed improvements in several measurement categories in Alabama. VOICES specifically credited the ACDRS for its “positive impact on further reducing preventable deaths.” The significant decline in preventable child deaths can be attributed to the involvement of the ACDRS in successful outreach, education and awareness, and policy efforts statewide.

While we celebrate the success of the ACDRS, prevention efforts are still a priority. Vehicular deaths are still the leading category of preventable child deaths in our state. The most common theme in these vehicular deaths reported by our local review teams are inexperienced teen drivers and unrestrained or improperly restrained child passengers. The second leading category of preventable child deaths is infant sleep-related deaths where the majority of the infant deaths occur in an unsafe sleep environment.

While measurable improvements have been made, the death of any child remains a sad and difficult event. The ACDRS along with our partners and stakeholders remain committed to the prevention of these child deaths. Prevention continues to be the mission and the number one goal of our staff and both state and local review teams.

ALABAMA CHILD DEATH REVIEW SYSTEM: CASE REVIEW TIMELINE (AN EXAMPLE)



- An infant or child death occurs on September 1, 2014.
- The death certificate is received at ACDRS State Office by November 1, 2014, barring delays. Delays sometime result in certificates being received several months after the death.
- The case is assigned to the appropriate Local Child Death Review Team (LCDRT) by November 15, 2014.
- The LCDRT meets to review this specific case and others during 2015 and/or 2016. (By law, each Local Team is required to meet only once per calendar year and all information necessary to the review process may not be available for several months after the death.)
- The ACDRS State Office receives the last of the 2014 death certificates by July 2015.
- April 1, 2017, is the deadline by which the ACDRS State Office is to receive all 2014 cases that have been reviewed and completed by LCDRTs.
- The ACDRS Annual Report on 2014 Data is published during 2017.





The Alabama Child Death Review System (ACDRS) is a grass-roots program driven largely by local citizen volunteers for the express purpose of protecting the lives of as many of Alabama's infants and children as possible. Our very effective State and Local Teams have contributed significantly to a reduction in preventable child injuries and deaths since ACDRS began, and we continue to see new efforts and great results from their hard work. We are delighted to report significant progress in both our data collection and our special interest programs:

Local Child Death Review Teams

The Alabama Child Death Review System has a Local Child Death Review Team (LCDRT) in every Judicial Circuit in the state. These teams continue to meet and review child death cases that occurred within their jurisdictions. Following the delays and challenges related to the transition between data collection systems, most Teams are now entering current data into the new national online collection system and case completion rates are beginning to approach past levels. We should again soon see the standard-setting levels that we experienced before retiring the old system thanks to the impressive efforts of our Local Teams.

ACDRS Training

In the past, ACDRS has conducted statewide training every other year, in even-numbered years. After conducting smaller regionalized trainings in 2010, ACDRS returned to a three day statewide training conference in 2012. The 2014 conference was held in September in Orange Beach and culminated with a quarterly State CDR Team meeting. The conference was well-attended and well-received.

Teen Driving Safety Campaign

In 2010, ACDRS began a multifaceted campaign to promote teen driving safety that continues today. We introduced a new website (www.acdrs.org/teendriving) and a new brochure, *Surviving Teen Driving*, both of which have been well-received. We also conducted a media campaign, promoting both of these new resources, which was publicly commended by the U.S. Secretary of Transportation. Vehicular deaths continue to be the leading cause of preventable child deaths in Alabama and safe teen driving, along with proper child passenger restraint and ATV safety, remains a primary issue of concern for ACDRS.

Alabama SUIDI Team

The CDC has established standardized tools and protocols for Sudden Unexplained Infant Death Investigation (SUIDI) which have been adopted nationwide. The ACDRS Director is proud to chair the Alabama SUIDI Team which has been codified as a sub-committee of the State CDR Team. The Team has developed a formal SUIDI training course for Alabama which is now required for all Coroners, Deputy Coroners, and certain law enforcement investigators. On-site training has been conducted for many groups of first responders statewide, and most of the state's Coroners and Deputy Coroners received the training at their annual conference. A distance learning approach will be employed for most future trainings. The dissemination of this important information should greatly improve infant death scene investigations, the accuracy of infant death diagnoses, and the overall usefulness of the information ACDRS collects regarding infant deaths.

The Alabama Cribs for Kids Program

The Cribs for Kids Program in Alabama began in Montgomery as a pilot program. Cribs, along with personal instruction regarding safe infant sleeping, have been provided to many qualifying families in the Montgomery County area with the help of the Gift of Life Foundation. After the success of the initial program there, Gift of Life and ACDRS expanded the program to other counties in the state. Jefferson, Mobile, Baldwin, and Escambia Counties now have similar programs in place and we hope to expand our efforts with the Cribs for Kids Program to other Alabama counties in the future.

Child Passenger Safety Efforts

The Booster Seat Advocacy Program is a joint effort of ACDRS, Children’s Hospital Child Safety Institute, UAB Department of Pediatrics, and the Alabama Department of Public Health’s Injury Prevention Branch. The program was initiated after the passage of the enhanced child restraint amendment in Alabama. Booster seats are provided to families throughout Alabama to ensure that children who are too large for infant seats but too small to be adequately protected by seat belts alone are protected while riding in passenger vehicles. ACDRS Central Office staff are all also trained Child Passenger Safety (CPS) Technicians and routinely conduct local CPS clinics in conjunction with other partners.

We have highlighted only some of the successes that we are seeing. Many others are identified throughout this report. We recognize that every death is more than just a statistic to Alabama families and other fellow citizens. Every single infant and child death is a terrible personal tragedy. We are dedicated to reducing the incidence of these tragedies as much as possible.



ALABAMA CHILD DEATH REVIEW SYSTEM FREQUENTLY ASKED QUESTIONS



1. What is ACDRS?

- Alabama is one of 49 states that has Child Death Review (CDR).
- Alabama state law signed on September 11, 1997, created the ACDRS State Office and both Local and State CDR Teams.
- ACDRS is tasked to review, evaluate, and prevent cases of unexpected/unexplained child deaths.

2. What is the “Mission” of ACDRS?

- To understand how and why children die in Alabama in order to prevent future child deaths.

3. What is the primary focus of ACDRS?

- The primary purpose of ACDRS is prevention, not prosecution. This is done through statistical analysis, education and advocacy efforts, and local community involvement.
- “Preventability” refers to the ability of an individual or community to reasonably have done something to alter the conditions that led to the child’s death, thereby preventing the child’s death, or to reasonably do something now to reduce the likelihood of future similar deaths.

4. How is ACDRS organized?

- ACDRS is comprised of three major components:
 - The ACDRS State Office is located in the Alabama Department of Public Health, within the Children’s Health Division of the Bureau of Family Health Services. There are three full-time staff members – Director, Assistant Director, and Administrative Assistant.
 - State Law requires each District Attorney to form at least one Local Child Death Review Team (LCDRT) in each Alabama Judicial Circuit. LCDRTs are multi-disciplinary and are required to meet at least once per year (most meet more frequently).
 - The State Child Death Review Team (SCDRT), chaired by the State Health Officer (Director of the Alabama Department of Public Health), is also multi-disciplinary and meets quarterly. Its 28 members include various state agency directors and representatives, medical professionals, judicial and law-enforcement officials, state legislators, and private citizens appointed by the Governor.
- Because of these components ACDRS considers itself a “system.”



5. How is ACDRS funded?

- Funding originates in Alabama’s portion of the National Tobacco Settlement (NTS) through the Children First Trust Fund (CFTF).
- The amount equals one half of 1 percent of the total CFTF portion of the NTS not to exceed \$300,000.
- The Alabama Medicaid Agency now also provides some supplemental funding to ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

6. What does ACDRS do?

- Analyzes the deaths of Alabama’s children
- Makes recommendations to the Governor
- Recommends and supports legislation
- Helps create policy and procedures
- Educates the public
- Helps to reduce infant and child deaths in Alabama

7. How does ACDRS operate?

- The ACDRS State Office receives a copy of all death certificates issued in Alabama for decedents less than 18 years of age. Each certificate is reviewed to determine whether it meets ACDRS review criteria. Cases meeting the criteria are then assigned to the appropriate LCDRT on a case-by-case basis.
- The LCDRT reviews the individual cases and, based upon its findings, completes the appropriate data collection forms and submits the information to the ACDRS State Office. The Local Team then takes action as allowed and/or required in the community to prevent additional deaths and makes recommendations to the State Team for consideration and action.
- The ACDRS State Office collects and analyzes the information submitted by the LCDRTs. This information is used to answer requests for specific data and to generate reports.
- The State Child Death Review Team meets quarterly to discuss Child Death Review (CDR) issues, review the statewide data, consider LCDRT recommendations and performance, and conduct general ACDRS business. The SCDRT makes periodic recommendations to the Governor and takes action on issues related to CDR (educational programs, informational publications, and other efforts).
- All formal recommendations and prevention efforts are evidence-based and goal-oriented.

8. What is included within ACDRS case review criteria?

- The deceased must have died in Alabama.
- The deceased must have been born alive (ACDRS does not review fetal deaths).
- The deceased must be less than 18 years of age.
- The cause of death must be non-medical, unexplained, and/or unexpected.

9. What are ACDRS goals?

- All Alabama death certificates assessed for review criteria
- All eligible cases reviewed at the local level by the appropriate LCDRT
- High participation and completion rate by the LCDRTs
- Meaningful research and recommendations
- Increased public awareness and understanding of risks
- Reductions in preventable infant and child deaths in Alabama

DEFINITIONS



- ◆ **Cases That Meet the Criteria for Review** – These are cases involving the deaths in Alabama of infants and children from live birth to less than 18 years of age whose deaths are considered unexpected or unexplained.
- ◆ **Cause of Death** – As used in this report, the term “cause of death” refers to the underlying cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.
- ◆ **Reviewed Cases** – This term includes those cases that were reviewed by a Local Child Death Review Team and added to the Alabama Child Death Review System (ACDRS) database.
- ◆ **Manner of Death** – This is one of six general categories (Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes) that is found in Item #49 on an Alabama Death Certificate.
- ◆ **Natural Causes** – A manner or cause of death by other than external means (the expected outcome of a disease, birth defect, or congenital anomaly). ACDRS normally will not review such cases. However, many cases in which the cause of death is initially classified as “Pending” or “Undetermined/Unknown” are later discovered to have been death by “Natural Causes.” This is why there are so many in this category included in the data. Sudden Infant Death Syndrome (SIDS) is considered a natural cause of death, but Local Child Death Review Teams are required by law to review all SIDS deaths.
- ◆ **Residential Institutions** – As used in this report, this is a term that identifies a place of death. Included in this classification are hospitals and emergency rooms. The number of deaths that occur in this category is usually fairly high because frequently victims survive long enough to reach the hospital, but then expire there.
- ◆ **Sudden Infant Death Syndrome (SIDS)** – This is a very specific type of SUID (see below) in infants from one month to 1 year old in which all external contributing causes are eliminated through complete autopsy and toxicology, review of the clinical history, and thorough death scene investigation.
- ◆ **Sudden Unexplained Infant Death (SUID)** – This is a broad term used to describe sudden infant deaths from a variety of both internal and external causes.
- ◆ **Unexpected/Unexplained** – In referring to a child’s death, this category includes all deaths that, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.



ALABAMA STATE CHILD DEATH REVIEW TEAM RECOMMENDATIONS TO THE GOVERNOR



Vehicular deaths are the leading category of preventable deaths to Alabama children less than 18 years of age reviewed by ACDRS and, in fact, account for approximately half of all such deaths in any given year.

The State Child Death Review Team recommends:

Comprehensive statewide awareness and education campaigns related to teen driver safety and child passenger safety

Enhancements to the current Graduated Driver's License (GDL) Law to include:

Significantly reducing the number of passengers allowed for the GDL driver

Increasing the limitations on late-hour driving under the GDL

Prohibiting the GDL driver from using distracting electronic devices while driving

Enhancements to and stricter enforcement of child passenger restraint laws

Establishment of a minimum age to operate ATVs

Safety training requirements for ATV operators

Prohibition of passengers from open truck beds on public roads

Infant sleep-related deaths are the second-leading category of preventable deaths to Alabama children less than 18 years of age reviewed by ACDRS and are by far the most likely cases to be misdiagnosed as to their manners and causes.

The State Child Death Review Team recommends:

A comprehensive statewide safe infant sleep awareness and education campaign

Support and promote the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team's curriculum and training courses



KEY DATES FOR 2015



- **January 22** STATE TEAM MEETING
- **March 15-21** NATIONAL POISON PREVENTION WEEK
- **March 23-27** NATIONAL YOUTH VIOLENCE PREVENTION WEEK
- **April** NATIONAL CHILD ABUSE PREVENTION MONTH
- **April 1** DEADLINE FOR SUBMISSION OF ALL CALENDAR YEAR 2012 CASE REVIEWS

- **April 16** STATE TEAM MEETING
- **July 16** STATE TEAM MEETING
- **September** NATIONAL INFANT MORTALITY AWARENESS MONTH
- **September** NATIONAL SUICIDE PREVENTION MONTH
- **September 13-19** CHILD PASSENGER SAFETY WEEK
- **October** NATIONAL SIDS AWARENESS MONTH
- **October** NATIONAL FIRE PREVENTION WEEK
- **October 15** STATE TEAM MEETING
- **October 18-24** NATIONAL TEEN DRIVER SAFETY WEEK





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